Attachment B-Final Report

SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS

Critical Incident

Part II: Final Report

Note:

- An internal management review will be conducted of all critical incidents. Results of all reviews will be sent to the DDSN Director of Quality Management within 10 working days of the incident or whenever staff first became aware of the incident (post marked or fax dated within that period of time). The final written report is completed using this form.
- Submission for consumers residing in ICF facilities should be within 5 working days of the incident to comply with DHEC requirements.

Provider/Regional Center: _____ **County:** _____

District I: ☐ Midlands ☐ Piedmont **District II:** ☐ Coastal ☐ Pee Dee

Type Facility: ☐ DDSN Contracted Provider ☐ DDSN Regional Center ☐ DDSN Operated Facility (Autism program)

Location of Occurrence: (indicate name of DDSN facility, i.e., Coastal Center, provider operated facility, i.e., Sunrise CTH II or address in community, i.e., individual's home or other address) _____

Date of Incident: **Time of Incident:** ☐ AM ☐ PM

Name of Primary Identifier: _____

(Indicate the name of the primary person involved. If incident occurred on van/in facility/in a situation where all names are not listed, specify as such)

Results of Management Review:

Describe action taken:

Review Outcome:

☐ Rules, Regulations or Policy Violation(s) (Specify which rule, regulation or policy was violated):	☐ Disciplinary Action Taken (Indicate action taken): ☐ Oral reprimand ☐ Written Warning ☐ Suspension ☐ Dismissal
☐ Management Action Taken: (Specify what action was taken):	☐ Other (Specify):
Comments:	

Is this incident a repeat occurrence with this consumer? ☐ Yes ☐ No

What quality assurance actions were taken to prevent the occurrence of an incident like this?

Reporting: If the incident was reported to another agency, please indicate which agency:

☐ DHEC ☐ DSS ☐ Ombudsman
☐ Law Enforcement ☐ Other: (Specify):

Reported by whom? _____ Title: _____

Signature:

_____

Executive Director/ CEO/ Facility Administrator (or Designee for Executive Director/ CEO/ Facility Administrator) Date Name of Person Completing Form

This document should be sent to:
Director of Quality Management, SCDDSN, PO Box 4706, Columbia, SC 29240, Fax #: 803.898.7450